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Abstract

Objective: This paper examines the types of goals being set by individuals in the context of Australian mental health services and whether goal type differs across the stages of recovery. Methods: Goal records of 144 individuals accessing services were reviewed to examine goal content, ratio of approach and avoidance oriented goals and changes across stages of psychological recovery. Results: Individuals further along in their recovery set significantly more approach goals and types of goals set appeared to reflect broader life roles. Conclusions and Implications for Practice: Setting approach goals and goals that reflect broader life roles tends to support the definition of psychological recovery as being "the movement towards" greater meaning and enhanced sense of self.

Keywords

avoidance, contrast, meaning, being, well, symptoms, towards, recovery, movement, health, mental

Disciplines

Arts and Humanities | Life Sciences | Medicine and Health Sciences | Social and Behavioral Sciences

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ARTICLE

**Recovery in Mental Health:
A Movement Towards Well-Being
and Meaning in Contrast to an
Avoidance of Symptoms**

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Objective: This paper examines the types of goals being set by individuals in the context of Australian mental health services and whether goal type differs across the stages of recovery. **Methods:** Goal records of 144 individuals accessing services were reviewed to examine goal content, ratio of approach and avoidance oriented goals and changes across stages of psychological recovery. **Results:** Individuals further along in their recovery set significantly more approach goals and types of goals set appeared to reflect broader life roles. **Conclusions and Implications for Practice:** Setting approach goals and goals that reflect broader life roles tends to support the definition of psychological recovery as being “the movement towards” greater meaning and enhanced sense of self.

Keywords: goal setting and striving, recovery, psychiatric disability, well-being

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Psychological recovery has been defined as “the establishment of a fulfilling, meaningful life and a positive sense of identity” (Andresen, Oades, & Caputi, 2003, p. 588). Goal setting within psychosocial rehabilitation and case management contexts is a forum where these hopes for the future can be identified and explored. Yet little is known about the types of goals established within the process of recovery from psychiatric disability (Stein, Mann, & Hunt, 2007) and whether different types of goals are more frequent within different stages of psychological recovery.

Goal content is what the goal refers to (e.g. exercise, employment). Understanding goal content can aid identification of resources available

to individuals to assist psychological recovery and may act as a needs analysis for service development.

Andresen and colleagues (2003) proposed a five-stage model of psychological recovery based on a review of recovery literature and qualitative research (See Table 1). Based on the conceptualization of these stages it may be expected that different types of goals may be set at different stages of recovery. The process of psychological recovery has been likened to the process of human development (Andresen, 2007). This suggests that as people progress in recovery and their more basic needs (physiological, safety) are met they may start to pursue goals that aim to achieve higher order human needs, such as love, esteem

TABLE 1—A STAGE MODEL OF RECOVERY (ANDRESEN ET AL., 2003)

Stage	Description
Moratorium	Characterized by denial of illness, identity confusion, social withdrawal and feelings of hopelessness.
Awareness	Awareness there is the possibility of a more hopeful future, a self not defined by illness.
Preparation	Starts to take steps towards recovery and focus on identifying values/strengths and connecting with peers.
Rebuilding	Actively working toward a positive identity. Focus on goals and taking responsibility for one's life.
Growth	Living a full and meaningful life and positive sense of self despite illness. They are resilient and able to manage illness despite setbacks. This stage is highly reflective of psychological well-being.

and self-actualization (Maslow, 1987). It may be expected that within early stages of psychological recovery, goals associated with physical health and basic day-to-day functioning are set. Whereas, as the person progresses within his/her recovery, goals may diversify and reflect life roles such as connection with others, occupational pursuits and striving toward self-actualization reflecting higher order needs. It should be noted that just as the experience of human development differs for individuals, so does the experience of recovery. The experience of recovery is an individualized process (Andresen et al., 2003; Anthony, Cohen, Farkas, & Cohen, 2000). This paper aims to examine whether there are themes across these unique experiences.

The *avoidance* and *approach* oriented goal distinction refers to the motivational drive underlying the goal (Carver & Scheier, 1990). *Avoidance* goals aim to move or stay away from a negative or undesirable outcome (e.g. "to stop hearing voices") whereas, *approach* goals aim to move towards or maintain a positive or desirable outcome ("buy a car," Carver & Scheier, 1990). Just as the content of goals set within psychosocial rehabilitation may differ depending on stage of recovery, so might the frequency of *approach* and *avoidance* goals. Within non-clinical samples an association between *avoidance* goals and poor psychological well-being and greater psychopathological symptoms has been

found (Elliot & Church, 2002). *Approach* goals have been associated with gains in psychological well-being and self identity (Elliot, Sheldon & Church, 1997). Both psychological well-being and self-identity have been noted as important aspects of psychological recovery and are thought to develop as people progress in recovery (Andresen et al., 2003). Therefore, it may be expected that people in the earlier stages of recovery will have a greater number of *avoidance* goals, whereas people in the later stages of recovery, a greater number of *approach* goals.

This research aims to: 1) describe the types of goals set within Australian mental health services, 2) determine whether certain types of goals are more likely to be set within different stages of recovery, and 3) determine whether there is a difference in the frequency of *approach* and *avoidance* goals set at different stages of recovery. It should be noted that the research does not aim to promote a model of case-management goals by suggesting that every person within the same stage of recovery will have the same goal content. To the contrary, it aims to expand clinicians,' researchers,' services' and the broader community's awareness of recovery goals so that we can better assist the consumer with his/her individual recovery journey. For example, a clinician may be alerted to the types of goals within different stages and may be less

inclined to push goals that are not reflective of the consumer's present stage of readiness. It may also promote dialogue between the consumer and clinician to increase reflection of the consumer's experience by drawing on the research examples.

Based on the Moratorium stage being characterized by a lack of hope and previous life goals, coupled with Maslow's (1987) hierarchy of needs it is expected that: Within this stage there will be a higher frequency of health goals when compared to occupational, social, educational, self-management/personal development goals. It is also expected there will be a negative relationship between the level of self-rated recovery and the frequency of physical health goals, indicating as one progresses in recovery her/his focus of goal content will shift away from health goals.

Based on the conceptualization of Preparation and Rebuilding stages focusing on developing both internal resources, building personal strengths as well as connecting and promoting social support it is expected there will be a greater frequency of self-management and relationship goals developed in the middle stage of recovery (Preparation and Rebuilding stage) when compared to the earlier stages of recovery (Moratorium, Awareness).

The Growth stage is largely characterized by people in recovery having a

sense of meaning, positive identity and a sense of control over their lives. Occupational and educational goals are often a source of meaning as noted in reflections made by individuals with psychiatric disability (Andresen, 2007). As people fulfill aspects of their lower order needs (physiological, security, love/connection respectively) they strive towards higher order needs, such as employment (Maslow, 1987). Therefore, it is expected that in the later stages of recovery (Rebuilding, Growth) there will be a higher frequency of occupational and educational goals developed.

Method

Participants

Individuals in recovery and their mental health workers were drawn from the Australian Integrated Mental Health Initiative sample (AIMhi, Oades et al., 2005).

Participants with Psychiatric Disability

Of the 242 individuals with psychiatric disability who agreed to participate in the AIMhi study, 144 (52% male) were included in the current study based on availability of goal records. Sixty-nine percent of participants had a diagnosis of Schizophrenia, 13% Bipolar Disorder, 12% Schizoaffective Disorder, and 6% Major Depressive Disorder with psychotic features. The average age of the participants with psychiatric disability was 39.34 years ($SD = 11.68$, range 18 to 69 years).

Mental health worker participants

Eighty-three mental health workers (75% female) participated (Mean age = 40.12 years, $SD = 10.56$, range 23 to 61 years). This included nurses (34%), support workers (25%), psychologists (21%), social workers (11%), welfare workers (8%), and occupational therapists (5%). Participants worked in adult

community mental health (44%), rehabilitation (44%), assertive community treatment team (10%), and crisis services (2%) settings.

Measures

Collaborative Goal Technology (CGT), Clarke, Oades, Crowe, & Deane, 2006) is a goal setting intervention developed for use within psychosocial rehabilitation contexts and promotes collaboration between the individual in recovery and mental health worker. The CGT incorporates goal-setting principles to enhance goal attainment and promotes recovery as an individualized process.

Recovery Goal Taxonomy (RGT) is a goal/striving taxonomy developed for this study to categorize goals into domains. The RGT aligns with principles on how to develop effective goal taxonomies (Grosse Holtforth & Grawe, 2002; Clarke, 2009). The initial 10 domains were drawn from value domains commonly identified in Acceptance and Commitment Therapy (ACT - Eifert, Forsyth & Hayes, 2005). Values are super-ordinate to goals and enable goals to be grouped under broader domains (Hayes & Strosahl, 2004). The ACT value domains seemed appropriate as they enabled goals set at different levels of abstraction to be grouped effectively without making an assumption about the motivational drive. The ACT value domains have previously been used with mental health populations (Hayes & Strosahl, 2004), and consist of: "couples and romantic relationships"; "parenting"; "family relationships"; "friendships and social relationships"; "work, career and employment"; "education and schooling"; "recreation, leisure, and sport"; "spirituality and religion"; "community and citizenship"; "physical health and well-being." The remaining four domains ("psychological and emotional health," "self management," "house and

home" and "self image and personal growth") were developed to accommodate goals that were not adequately categorized with the ACT value domains.

The Self Identified Stage of Recovery

(SISR, Andresen et al., 2003; Andresen, Caputi, & Oades, 2010) is a single item measure that enables individuals with psychiatric disability to identify their current stage of recovery in relation to a five-stage model. The participant selects one statement from five provided that best describes his/her experience of recovery over the past month. The SISR correlates with other measures of recovery such as the Recovery Assessment Scale (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999; $r = .26$, $p < .01$) and the Mental Health Recovery Measure (Young, Ensing, & Bullock, 2000; $r = .28$, $p < .01$; Andresen, Oades, & Caputi, 2003).

The Recovery Assessment Scale-Short

(RAS-s; Corrigan, Salzer, Ralph, Sangster, & Keck, 2004) is a 24-item continuous measure of self-rated recovery. Items are responded to on a five-point scale from 0 (Strongly disagree) to 4 (Strongly agree). Participants rate the extent to which they agree or disagree with a series of statements (e.g. "I believe I can meet my current personal goals").

Procedure

For each participant a data point was selected based on the availability of a CGT and recovery measure (SISR and/or RAS-s) falling within the same three-month time frame. One hundred and five consumers had completed a CGT and SISR and 111 participants had completed a CGT and RAS-s at the same time point. For the remaining participants where there was no data time-point that contained both a CGT and recovery measure (RAS-s and/or SISR), their first CGT was used to assess goal content. Only one data point was selected for each participant. A total of

386 ($N = 144$) goals (this included the 144 goals that each consumer rated as most important on their CGT) were categorized into one of the 14 goal domains and were analyzed using the Statistical Package for Social Sciences (SPSS). To assess inter-rater reliability of goal categories, an independent research assistant co-rated the goals. The Kappa co-efficient was high (.93), indicating the goals could be reliably categorized using the 14 goal domains.

When examining data related to types of goals across stages of recovery and the recovery measures (SISR and RAS-s), only the participant's most important goal was selected. This was to ensure goals examined were those the person in recovery was more motivated to achieve and for ease of statistical analysis. The RGT value domains were further grouped into larger overarching domains to enable appropriate analysis (e.g. Chi Square analysis). The "Physical" and "Psychological and Emotional Health" value domains were grouped under the category of "Health" and goals categorized as "Parenting," "Family" and "Friendships/Social" were combined into a single larger "Relationship" domain. The "Spiritual/Religious" goal domain was removed from the analysis as only one participant rated this goal as most important. The "Couples and Romantic Relationships," "Personal Growth and Self-Image" and "Community and Citizenship" RGT domains were not included in the analysis as none of the participants' goals could be categorized under these domains. Seven overarching RGT value domains remained consisting of: "Relationships," "Employment," "Health," "Education," "Self-Management," "Recreation," and "House and Homecare." Participants

TABLE 2—CONTENT OF CASE-MANAGEMENT GOALS

Goal domain	Frequency		Most important	Examples of goals
	%	<i>n</i>	% <i>n</i>	
Physical health	21	(82)	23 (33)	Take medication as prescribed
House and home	14	(53)	11 (16)	Purchase new furnishings
Work/career/employment	11	(44)	14 (20)	Get paid employment
Psychological health	10	(39)	12 (17)	Manage my panic attacks
Recreation/leisure/sport	10	(39)	9 (13)	Explore hobbies
Self-management	10	(39)	9 (13)	Day to day routine
Education/schooling	8	(29)	12 (17)	Complete literacy course
Friendships and social	7	(28)	7 (10)	More social activities
Parenting	3	(12)	3 (5)	House ready for son's birthday
Personal growth	2	(7)	0 (0)	Develop my creative skill
Family relationships	2	(6)	3 (5)	Make the most of my parents
Couples and romantic	1	(3)	0 (0)	Get a girlfriend
Spirituality and religion	1	(3)	1 (1)	Go to church weekly
Community	.2	(1)	0 (0)	Tell others about mental health

Note. Frequency of all goals includes all case-management goals set within the three-month period selected for each consumer. This is between one to three goals per consumer participant. Most important goal relates to the one goal that consumers rated as most important.

who completed the SISR had their most important goal also coded into either *approach* or *avoidance* goals ($N = 105$).

Results

Physical health goals (21% of all goals) were the most frequently reported goal

and were rated as the most important goal by 23% of participants. Many of the other goal domains showed similar frequencies. Refer to Table 2 for frequencies of goals and most important goals. Goals associated with the development or maintenance of relationships (social, parenting, intimate relationships and family relationship)

TABLE 3—GOAL CONTENT ACROSS THE FIVE STAGES OF RECOVERY

Overarching value domains	Moratorium		Awareness		Preparation		Rebuilding		Growth	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Relationships	12	(2)	12	(2)	24	(4)	35	(6)	18	(3)
Employment	7	(1)	21	(3)	14	(2)	29	(4)	29	(4)
Education	25	(1)	25	(1)	25	(1)	25	(1)	0	(0)
Health	28	(10)	6	(2)	31	(11)	14	(5)	23	(8)
Recreation	11	(1)	11	(1)	33	(3)	11	(1)	33	(3)
House & Home	17	(2)	0	(0)	8	(1)	25	(3)	50	(6)
Self-Management	8	(1)	8	(1)	33	(4)	25	(3)	25	(3)

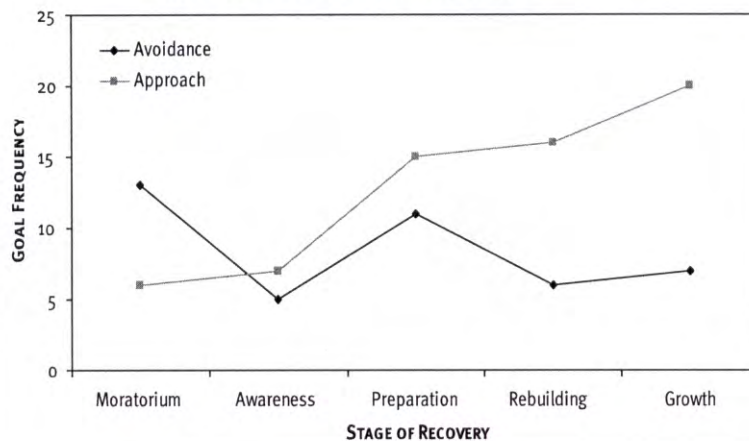
TABLE 4—FREQUENCY OF APPROACH AND AVOIDANCE GOALS FOR STAGES OF PSYCHOLOGICAL RECOVERY

Approach/ Avoidance	Moratorium % n	Awareness % n	Preparation % n	Rebuilding % n	Growth % n
Avoidance	12 (13)	5 (5)	10 (11)	6 (6)	7 (7)
Approach	6 (6)	7 (7)	14 (15)	16 (15)	19 (20)

were rated by 15% of individuals as their most important psychosocial rehabilitation goal. Employment goals

than other goals set within the Moratorium stage ($\chi^2 (6, N = 18) = 25.56, p < .01$), supporting the first hypothesis.

FIGURE 1—FREQUENCY OF APPROACH AND AVOIDANCE GOALS ACROSS THE STAGES OF PSYCHOLOGICAL RECOVERY.



were noted as the most important goals by 14% of participants.

Goal Content and Recovery

Fifty-six percent ($n = 10$) of goals set in the Moratorium stage were "Health" goals (refer to Table 3). Chi square analysis revealed that health goals occurred significantly more frequently

The high number of health goals within this stage appears to be due to the high frequency of *avoidance* physical health goals (Refer Table 4).

Within the Preparation stage there was a significantly greater number of health goals (44% of goals set, $n = 11$, refer to Table 3) than goals within the other

overarching value domains ($\chi^2 (6, N = 26) = 19.23, p < .01$). This suggests individuals in Preparation stage are more inclined to set psychosocial rehabilitation goals associated with improving their health (physical and psychological) than strive toward other types of goals. The high frequency of health goals within the Preparation stage appears to be due to a high number of avoidance psychological health goals. No other statistically significant differences between goal types and stage of recovery were evident.

Refer to Table 4 and Figure 1 for frequencies of *approach* and *avoidance* goals for each stage of psychological recovery. Cross Tabs analysis revealed a significant difference between frequency of *approach* and *avoidance* goals across the stages of psychological recovery ($\chi^2 (4, N = 106) = 10.21, p < .05$). There were significantly more *approach* goals set within the Rebuilding ($\chi^2 (1, N = 22) = 4.54, p < .05$) and Growth ($\chi^2 (1, N = 27) = 6.26, p < .05$) stages of recovery.

A Spearman's correlation was conducted using the service participants' most important goal categorized within the seven overarching goal domains and score on the RAS-s. Significant positive correlations were found between RAS-s score and frequency of relationship goals ($r (109) = .20, p < .05$). This suggests people who are more advanced in their journey of recovery are setting more relationship goals. A significant negative correlation was also evident between health goals and RAS-s total scores ($r (109) = -.22, p < .05$). This suggests people who reported lower self-rated levels of recovery are more inclined to set health goals within psychiatric rehabilitation. This is consistent with the hypotheses proposed. No significant relationship was found between level of self-rated recovery and

TABLE 5—SPEARMAN'S CORRELATION COEFFICIENTS EXAMINING VALUE DOMAINS WITH THE RAS-S

	Relationship	Employment	Health	Education	Recreation	House
RAS-s	.20*	.09	-.22*	-.05	.01	-.09

Note. $N = 111$. No participant who completed the RAS-s set goals that fell within the self-management goal domain. * $p < .05$.

employment goals as hypothesized ($r(109) = .09, p > .05$).

Discussion

Physical health goals were recorded significantly more frequently and were rated as the most important goal by nearly a quarter of all service participants. Physical health goals included goals focusing on weight loss, increased exercise, improved nutrition, and management of physical illnesses and mental health medication. This may be related to the increase in physical health problems and illness severity experienced by individuals with psychiatric disability (Coghlan, Lawrence, Holman, & Jablensky, 2001; NASMHPD, 2006) as well as the majority of the participants utilizing medication as one means of managing their mental illness. It should also be noted that there are often detrimental side effects associated with pharmacotherapy including weight gain, which in turn is associated with many physical illnesses (e.g. diabetes, metabolic syndrome etc.; NASMHPD, 2006). Perhaps the focus on health goals at this early stage in recovery may also be related to managing some of these negative side effects to prevent physical disease.

Employment and career goals also seemed of high importance. Employment goals are often an important source of meaning and competency for individuals with psychiatric disability (Waghorn, Collister, Killackey, & Sheering, 2007). The rate of employment of individuals with psychiatric disability within Australia is only 34% compared to 80% of the general population (Engage, 2005). This suggests despite striving for employment goals the actual rate of employment amongst this group is relatively low. State and local government initiatives to assist individuals in recovery to find employment and access training

are vital. Goals focused on relationships were the third most frequently rated most important goal, suggesting that social support is central to the recovery process.

Stage of Recovery and Goal Content

As predicted there were significantly more "Health" goals (56%) set at the Moratorium stage than other goals. The Moratorium stage is characterized by lack of hope, identity and a sense of powerless and loss over the goals associated with various areas of the individual's life (e.g. social, occupation, education; Andresen et al., 2003). This was reflected by the relatively fewer number of non-health specific goals being set in this stage. As the Moratorium stage is typically the first stage encountered following the mental health diagnosis we may expect the mental illness to be a significant focus for psychosocial rehabilitation, which includes goals within this "health" domain. Results from the RAS-s also found health goals were significantly more likely to be set in the earlier stages of recovery.

This high number of health goals may be due to these types of goals being typically practical and concrete. King (1998) noted that when life goals become unattainable, day-to-day goals may buffer against depression and provide a sense of agency. Health goals may also be more prevalent at this time as they may be more reflective of goals promoted by the mental health worker rather than reflecting the individual's personal goals.

Reflecting on Maslow's (1987) hierarchy of needs offers another possible interpretation of the high prevalence of health goals earlier in recovery. Maslow noted that an individual typically requires a sense of security in the world and to be free from anxiety prior to moving towards needs associated

with connection and self-esteem. The experience of mental illness is often frightening and the individual may experience a sense of powerlessness over his/her life and experience (Andresen et al., 2003). This may suggest that "health" goals, which in part focus on management of mental health issues, need to be at least somewhat met prior to establishing goals associated with relationships, employment and personal development. The current findings show that individuals with psychiatric disability are regularly setting goals and are planning for the future, not just focusing on immediate needs, even within the early stages of the recovery process.

Participants were also significantly more likely to set health goals than other goals in the Preparation stage. This was related to the high frequency of *avoidance* psychological goals set during this stage of recovery. The Preparation stage is characterized as the individual setting the foundation for recovery by promoting both internal and external resources, which included a focus on mental health treatment (Andresen et al., 2003). Within this stage many of the health goals set aim to reduce negative psychological experiences (e.g. to reduce panic attacks, to stop feeling depressed).

Higher scores on the RAS-s were associated with setting relationship goals, supporting the idea that people further along in their recovery are more focused on developing and maintaining their relationships. The need for relatedness and connection is an important human need (Deci & Ryan, 1985) and a good social network correlates significantly with greater progression in recovery (Corrigan & Phelan, 2004).

There was a general increase in the number of *approach* goals as stage of psychological recovery progressed. This signified people within early

stages of recovery showed greater *avoidance* goals and less *approach* goals than people in later stages of recovery. There were significantly more *approach* than *avoidance* goals in the final two recovery stages (Rebuilding, Growth). This reflects previous research that *approach* goals are associated with improved psychological well-being. This supports Keyes' (2002) concept of flourishing and starts to shape progression in recovery as movement towards health and meaning rather than avoidance of symptoms. It should be noted that just as the process of human development differs for individuals, recovery is also not a standardized or linear process. Individuals don't all systematically follow each stage and do not progress at the same pace. Individuals often experience setbacks within recovery which can lead to a few steps back before progressing again.

One limitation is the number of participants involved when looking at the relationship between goal content and recovery. As investigating this relationship requires participants to be grouped according to goal content, this led to small numbers within each goal domain, reducing power of the analysis. Results should be viewed with this in mind, and further research would assist in determining whether these results are robust and can be generalized. As the research drew on participants from the AIMhi project, each of the mental health workers were trained in the Collaborative Recovery Model (Oades et al., 2005). Therefore, perhaps this sample may be more recovery oriented than more traditional services, suggesting the data might not be entirely representative of goals developed within psychosocial rehabilitation where a more traditional model of treatment delivery is prominent. Furthermore, content of goals and stage of recovery was only examined

using cross-sectional data. Future longitudinal research would also be beneficial to examine whether consumers' goal content changes over time as they move through the stages of psychological recovery. However, despite these limitations the current research provides insight into how goal content differs across stages of psychological recovery from serious mental illnesses. Future research employing another stage of recovery measure would be beneficial to determine whether these results can be replicated. Moreover, further exploration of the dynamic dual process of *approach* and *avoidance* goals is warranted as a way of conceptualizing and understanding the complexity of recovery process.

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